

PARENTAL AGREEMENT FOR MEDICINES BROUGHT INTO SCHOOL (Prescribed or continuous Medicines only)

Name of pupil

Date of birth

Medical condition or illness

Medicine

Name/type of medicine
(as described on the container)

Expiry date

Dosage and method

Timing

Special precautions/other instructions

Are there any side effects that the
school/setting needs to know about?

Self-administration – yes /no

Procedures to take in an emergency

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name

Daytime telephone no.

Relationship to child

Address

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff to administer medicine and my child to self-administer medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s):

Date: